STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING 01 B. WING	04/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	1751 WESLEY ROAD AUBURN, IN46706

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/25/11 Facility Number: 000307 Provider Number: 155666 AIM Number: 100285660 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Wesley Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000	The creation and submission of this plan of correction does not constitue an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and request a desk review in lieu of a post survey review on or after May 18, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 69 and had a census of 43 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/29/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 2 of 20 penetrations caused by the passage of wire and/or conduit through the smoke	K0025	K025 NFPA 101 LIFE SAFETY CODE STANDARD1. The Maintenance man inspected and sealed all nonconforming gaps on the East Hall Fire Barrier Wall.2. The Maintenance man or his designee will inspect the fire	05/03/2011

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	barrier wall were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect two of four smoke compartments. Findings include: Based on observation with Executive Director on 04/25/11 at 2:02 p.m., there was a one fourth inch unsealed gap around each of the two clear plastic tube penetrations in the attic east hall smoke barrier wall. This was acknowledged by the Executive Director at the time of observation.		barrier wall on a monthly basis.3. The results of the inspections will be brought to QA for tracking quarterly for one year then annually thereafter.	

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K0029 SS=D	3.1-19(b) One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 hazardous areas, such as laundry room, latched into the door frame. This deficient practice was not in a resident care area but could affect any number of staff in the event of an emergency. Findings include: Based on an observation with the Administrator and Executive Director on 04/25/11 at 1:15 p.m., the clean laundry room corridor door did self close, but it failed to latch into the door frame. This was confirmed by the Administrator and Executive Director at the time of observations.	K0029	K0029The facility engaged an outside door repair company (A1 Door Company) to check and adjust the clean laundry room door. This service was completed on May 03, 2011	05/03/2011

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	3.1-19(b)			
K0050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on review of the "Fire Drill Report" forms with the Administrator and Executive Director on 04/25/11 at 12:20 p.m., all first shift fire drills took place between 10:40 a.m. and 11:20 a.m. for four of the last four quarters. This was acknowledged by the Administrator at the time of record review.	K0050	K 00501. The Administrator or his designee will conduct first shift fire drills at various times during the entire 8 hour shift.2. The results will be brought to QA for tracking and trending quarterly for one year then annually thereafter.	05/03/2011

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	3.1-19(b) 3.1-51(c)			
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure the spray pattern for 3 of 8 sprinkler heads in the main dining room was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect all residents in the main dining room. Findings include: Based on observation with the Administrator and Executive Director on 04/25/11 at 1:30 p.m., the spray pattern of three center sprinkler heads in the main	K0062	K 0062 The facilility has had the identified light fixtures moved sufficiently away from the sprinkler heads so the spray pattern will not be obstructed in any way.	05/03/2011

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	dining room was obstructed by a ceiling light fixture mounted five inches from each sprinkler head. This was acknowledged by the Administrator at the time of observation. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion	K0144	K01441. EMERGENCY SHUTOFF FOR EMERGENCY GENERATOR. The facility had an emergency shutoff switch mounted in the corridor outside of the transfer switch room.2. LETTER OF RELIABILTY FOR FUEL SOURCE. The facility has contacted and received an acceptable letter of reliability for fuel source from our natural gas provider (Northern Indiana Fuel and Light). See Attached PDF File.	05/18/2011

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	Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Administrator and Executive Director on 04/25/11 during a tour of the facility from 12:45 p.m. to 2:02 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Administrator and Executive Director at 12:25 p.m., the generator has a 350 cubic inch, V-8 engine. 3-1.19(b) 2. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems,			

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	Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquifed petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:			

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	1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all occupants. Findings include: Based on interview with the Administrator and Executive Director on 04/25/11 at 12:45 p.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (NIPSCO) dated June 30, 2008 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an			

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	emergency generator. The letter lacked supporting statements of reliability of natural gas and low probability of interruption of the natural gas service. This was acknowledged by the Administrator and Executive Director during the time of record review. 3.1-19(b)			